Welcome to Amazing Dental, we are so grateful that you chose our office for your dental needs.
Please carefully read our listed policies as they apply to all patients.

OFFICE POLICIES

• Due to the nature of this business we do see emergency patients that may cause the office to get behind schedule. Sometimes this will cause scheduled appointments to be delayed, in the event that this happens our staff will notify you upon your arrival and make accommodations accordingly.
• Please understand that there is a $25-$100 fee for all cancellations not made 24 hours prior to appointment date and for ALL NO SHOWS. Also, if you have three or more no show or cancelled appointments, we will ask you to find a new dentist.
• If your appointment requires a deposit, the deposit is due when the appointment is scheduled. If the appointment is missed or rescheduled in less than 24 hours the deposit will apply to the cancellation or no show fee.
• Office co-pays, deductibles, and any fees for service are due at the time the services are rendered.
• All x rays taken are part of our permanent records. We require a 24 hour notice if you would like a duplication of your x rays taken at this office. All patients requesting x rays are subject to a duplication fee of $25, whether the x rays are picked up from our office or sent to a different office.
• Please silence all electronics while in the dental operatory.
• A current photo ID is required for use of any insurance as well as all payments other than cash. (Checks, Credit Cards.....)
• Only the patient that is scheduled is allowed in the dental operatory.
  (If the patient is a minor a parent may accompany the child during the exam only)
• Please no food or drinks in the reception area we will supply our patients with water or coffee upon request.
• Also, if you are more than 15 minutes late to your appointment it may be necessary to reschedule your appointment.

By signing below you are agreeing that you have read and understood Amazing Dental's office policies.

Signed:_________________________  Date:_________________________
DENTAL INSURANCE AND FINANCIAL AGREEMENT

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff.

Thank you for choosing our office to provide your dental care. Our staff is dedicated to helping you achieve and maintain maximum oral health. If you would like for us to file a claim with your dental insurance, we will work hard to help you receive your maximum allowable benefit. In order to achieve this goal we need you to take the necessary steps to understanding your insurance plan. It is very important for you as the dental insurance policy holder, to be aware of the plan benefits, deductibles, and exclusions for your plan. Plan benefits can be obtained by calling your dental insurance company. We will gladly discuss your proposed treatment plan and answer any questions that you may have relating to your insurance. You however, must be aware of the following:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party in that contract.
2. Most insurance companies have a yearly deductible that is your responsibility to pay.
3. Most insurance companies only pay a percentage of the cost (such as 50% or 80%) and you will be responsible for the remainder.
4. Not all services rendered are a covered benefit with insurance. It is important for you to contact your insurance provider to ask if there are any clauses, exclusions, or waiting periods.
5. As a courtesy to you, our office will submit claims to your insurance provider. If for any reason the claims go unpaid you will be responsible for all charges not paid by the insurance.

If you have any questions regarding this information, or any uncertainty regarding insurance coverage please do not hesitate to ask us, we are here to help you in any way we can.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION

SIGNATURE_________________________ DATE_________________________

Dr. Aamir Budhani
2745 N Collins Suite 101
Arlington, Texas 76006
(817)484-5588
Written Financial Policy

Thank you for choosing Amazing Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover Card
- Convenient Monthly Payment Options¹ from Care Credit Patient Lending or Citi Health Card
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Amazing Dental requires payment at the beginning of your treatment and all appointments will require a deposit when scheduling the appointment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For plans requiring more than 2 appointments, alternative payment arrangements may be provided. For comprehensive appointments a deposit of $50 or more may be required to reserve your appointment. If your appointment is canceled then a $50 cancellation fee will apply and any funds remaining will be credited to your account or refunded to you.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.²

A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.

Amazing Dental charges $35 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_________________________   ____________________
Patient, Parent or Guardian Signature     Date

Patient Name (Please Print)

¹Subject to credit approval
²However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.
AURTHORIZATION TO DISCLOSE INFORMATION

I give the staff at Amazing Dental to discuss any of my treatment plans, diagnosis, or financial matters with the following names listed below. If at any time this changes I will notify the staff in writing and the person listed will be removed as an authorized person from my patient file. Please list any persons that may schedule or cancel any of your appointments as well. We follow the privacy laws and we can’t disclose any information on our patient, even to spouses or parents for patients over the age of 18.

Please List Persons Below:

1. ___________________________  Relationship_________________

2. ___________________________  Relationship_________________

Emergency Contact Information

1. ___________________________  Phone: ________________

Referred By: ________________________________
Patient Registration and Medical History Form

Date __________________ (please print) Home Phone (___)__________________

Patient

Last Name _______________ First Name ___________ Initial ___________ Preferred Name _______________

Street Address ___________________________ City ___________ State ___ Zip ______

Email address _________________________ Cell Phone (___) __________________

Sex: M ____ F ____ Age _____ Birthdate ____________

Single ____ Married ____ Widowed ____ Separated ____ Divorced ____

Employed by ______________________________________________________________________

Occupation ____________________________________________________________

Business Address: __________________________________________________________________

Business phone (___)____________________

Spouse/Parent Name ____________________________

Spouse/Parent Birthdate __________________

Spouse/Parent Employed by ______________________________________________________________________

Occupation ____________________________________________________________

Business Address: __________________________________________________________________

Business phone (___)____________________

Who is responsible for this account? __________________ Relationship to Patient ______________

Social Security # __________________________

Spouse/Parent’s Social Security # __________________________

Name of Dental Insurance Company __________________________

Group Number _______________

In case of emergency, who should be notified? __________________________

Emergency contact phone (___)____________________

Whom may we thank for referring you?

______________________________________________________________________________
MEDICAL HISTORY

Physician's Name ___________________________________________ Date of last physical ______________________

Have you ever had any of the following? (check all boxes that apply):

___ Heart Problems  ___ Epilepsy  ___ Special Diet
___ High Blood Pressure  ___ Headaches  ___ Swollen Neck Glands
___ Low Blood Pressure  ___ Hepatitis, Jaundice or liver disease  ___ Rheumatic Fever
___ Circulatory Problems  ___ Cancer  ___ Sinus Problems
___ Nervous Problems  ___ Psychiatric Care  ___ HIV/AIDS or Other
___ Radiation Treatment  ___ Chronic Diarrhea  Immunosuppressive disorders
___ Artificial Heart Valves or Joints  ___ Allergies to Anesthetics  ___ Stroke
___ Recent Weight Loss  ___ Allergies to Medicine or drugs  ___ Ulcer
___ Back Problems  ___ General Allergies  ___ Venereal Disease
___ Diabetes  ___ Blood Disease  ___ Chemical Dependency
___ Respiratory Disease  ___ Arthritis  ___ Hemophilia

Do you have any drug allergies or have you ever had an adverse reaction to any medication?

________________________________________________________________________

If so, what__________________________

Have you ever responded adversely to medical or dental treatment?

________________________________________________________________________

Are you taking any medication at this time? ____________________________

If so, what__________________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dextfenfluramine) Yes _____ or No _____

Are you under the care of a physician? Yes ____ No ____

For what conditions ____________________________

If patient is a child, what is his/her weight? ____________________________

(Woman) Do you suspect that you are pregnant? Yes ______ or No ______

Are you nursing? Yes _____ or No _____

Is there anything else we should know about your medical history? ____________________________

________________________________________________________________________

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ____________________________ Signature ____________________________
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect _______ and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a copy of access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 _____ per page, $60.00 _____ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Aamir Budhani
Telephone: 817-684-5588 Fax: 817-719-9351
E-mail: info@myamazingdental.com
Address: 2745 N Collins Suite 101 Arlington, Tx 76006

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